Performance

Report

**1800 951 822**

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| Name: | Homewood Residential Aged Care |
| Commission ID: | 3395 |
| Address: | 8 Young Road, HALLAM, Victoria, 3803 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 19 June 2024 |
| Performance report date: | 23 July 2024 |
| Service included in this assessment: | Provider: 1525 Bridgeast Pty Ltd  Service: 2152 Homewood Residential Aged Care |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Homewood Residential Aged Care (**the service**) has been prepared by V Plummer, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received on 8 July 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 7** **Human resources** | **Not applicable as not all requirements have been assessed** |
| **Standard 8** **Organisational governance** | **Not applicable as not all requirements have been assessed** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

Consumers and representatives provided positive feedback in relation to the clinical care the consumer receives and said known risks of consumers were managed effectively. Care planning documentation evidenced high-impact, high-prevalence risks were identified, assessed, and monitored with strategies in place, including, falls, unplanned weight loss, skin integrity, restrictive practices and changed behaviours and infections. Staff were able to describe the individual consumers’ risks and described strategies in place to manage and minimise those risks.

Care documentation evidenced staff are effectively monitoring, assessing, and managing consumers clinical needs. Interviews with management and review of service documentation, including incident management records, demonstrated effective management of high-impact and high-prevalence consumer risks. Staff were guided by policies and protocols, including a risk management framework.

The service collates incident data each month and analyses the information to identify clinical trends including high-impact or high-prevalence risks which is discussed at management and staff meetings.

The Approved Provider's response via email on July 8, 2024, to the assessment contact report acknowledges the feedback provided and states the actions currently in progress to enhance care delivery as part of the service's continuous improvement plan. These actions included:

* Wound management and monitoring of pressure injuries
* Nutrition and Hydration and the Dining Experience
* Clinical Care documentation
* Restrictive Practices, consent and best practice.
* Roster management including Personal Care Workers competencies.
* An Education/training calendar in place

I have considered the information within the assessment contact team report, placing weight on the details provided, including positive feedback from consumers and representatives, staff knowledge in managing consumer risks, and a documentation review which reflects effective management of those risks.

It is my decision Requirement 3(3)(b) is Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

Most consumers and representatives confirmed they were happy with the level of care provided and felt there were sufficient levels of staff to meet the consumer’s needs. Staff advised they have adequate time to complete their duties and confirmed vacant shifts or unplanned leave are immediately filled as required. Management demonstrated a range of strategies to replace staff on planned and unplanned leave including shift extension, recruiting additional casual staff, or providing additional shifts to existing staff. A review of the service’s roster evidenced a mix of clinical and care staff to provide care to consumers. Management described the ongoing recruitment and monitoring efforts the organisation is undertaking to ensure sufficiency of staffing to meet the consumers’ clinical and care needs effectively. The organisation is a registered training organisation which is utilised internally to train, educate, and recruit staff while undertaking formal qualification.

In relation to their workforce responsibilities, the service has a registered nurse on site and on duty 24 hours a day, 7 days a week (24/7) and there is additional clinical support provided by the care managers, team leaders and department managers throughout the day and after hours on-call if escalation is required.

In relation to meeting the mandatory care minutes requirements, the service acknowledged they have a shortfall and are not currently meeting the mandatory care and registered nurse minutes. However, the service provided information on the strategies they have in place to ensure the delivery of holistic care to consumers which they are unable to record as direct care minutes. These include full time medical officers on site, the use of a range of professional allied heath staff on site, extensive well-being staff, and counselling services undertaken by specialist counsellor and dementia support staff.

I have considered the information within the Assessment Team report, and I am satisfied the organisation ensures a workforce capable of delivering and managing safe and quality care and services. This is reinforced by the overall positive feedback from consumers, their representatives and staff regarding the delivery of care and services and the additional support established by the service to ensure any concerns are escalated and addressed in a timely manner.

It is my decision Requirement 7(3)(a) is Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Consumers and representatives advised they receive the clinical care they need. The organisation demonstrated a clinical governance framework which supports clinical care practice within the service and is monitored by the organisation at multiple levels. The service demonstrated clinical care practice is governed by organisational policies and procedures which are available and accessible electronically to guide staff in delivering safe and effective care. These include antimicrobial stewardship, minimising restrictive practices and open disclosure.

Staff demonstrated an understanding of high-impact and high-prevalence risks at the service and explained how they implement the service’s policies in line with best practice. Management and clinical staff were able to identify risks to individual consumers and described how they mitigate the consequences associated with these risks. The service has a suite of policies and procedures to help guide staff in the delivery of safe care and services. Staff interviewed demonstrated knowledge of the policies and where to find them.

Management highlighted a clinical governance committee oversees the development and implementation of legislative regulatory and operational responsibilities to ensure a strong safety culture across the organisation. The service demonstrated it has an effective incident management system in place. A review of clinical incident documentation confirmed incidents are recorded and actioned appropriately including actions taken at the time of the incident, reviews and referrals, notification of incidents to appropriate persons, improvement actions undertaken and reporting.

I have considered the information within the Assessment Team Report, and I have placed weight on the positive feedback from consumers, staff knowledge of the systems and processes in place, and the evidence of effective implementation of the clinical governance framework at the service.

It is my decision Requirement 8(3)(e) is Compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)